DHA UBO Webinar
Denials Management Best Practices

Ms. Jamie Edwards DHA UBO Support

May 2024

Objectives

- Review relevant legislation
- What is a Denial?
- Importance of Denials Management
- Explanation of Benefits (EOB) overview
- Identify reasons for claim denials
- Types of claim denials
- Learn how to effectively communicate with payers and MTF staff
- Discuss processes for handling claim denials
- Appealing claim denials
- Learn ways to track and manage claim denials and appeals

Relevant Legislation

- Title 10, United States Code, Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries

- Title 32, Code of Federal Regulations, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - ✓ Statutory obligation of third-party payers to pay; no assignment of benefits required
    - ✓ Certain payers excluded from Third Party Collection Program
    - ✓ Applicable charges
    - ✓ Rights and obligations of beneficiaries
    - ✓ Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

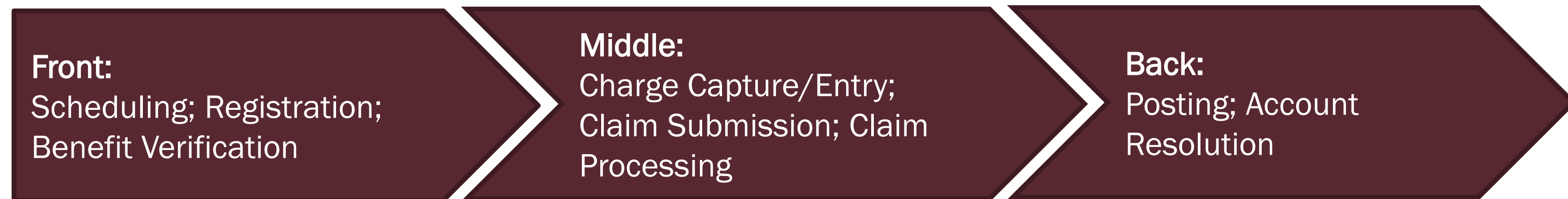
What is a Claim Denial?

- Health care industry does not have one universal definition of a claim denial:
  - "Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided." (HFMA)
  - "The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional." (healthinsurance.org)

Denials Management

- Why Is Denials Management So Difficult?
  - Complexity of third-party denials
  - Denial information provided by third-party payers is not standardized
  - Perceived inability to capture the denial data
  - Constantly changing information
  - Requires coordination throughout the revenue cycle
  - Challenging appeals process

Claim Denials Across Revenue Cycle



Front	Middle	Back
Member not Eligible	Missing/Incorrect Modifiers	Duplicate Claims
Termed Coverage	Not Medically Necessary	Previously Paid Claims
Non-Covered Charges	Missing Claim Information	Additional Claims Information Required
Out-of-Network Provider	Additional Clinical Information Required	Incorrect Denials
Member Cannot be Identified		

The Importance of Denials Management

- Why are effective denials management processes so important?
  - Denials have increased significantly as the electronic billing and remittance process becomes increasingly sophisticated
    - ✓ Claims have less "human" contact
    - ✓ Computer based payment algorithms search for key information according to payer contract requirements
  - The average cost to rework a claim is $25.00 (HFMA)
  - Failing to rework denials results in a loss of revenue that supports your MTF's operation and maintenance budget
  - Manageable accounts receivable

Explanation of Benefits (EOB)

- Definition and Purpose:
  - An EOB or Electronic Remittance Advice (ERA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied
  - The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full

Remittance Detail in CPA

Remittance Detail

Remittar

Filters Search

Count: 1 Claim Total: $121.35 Payment: $0.00 Adjustment: $0.00 Patient Liability: $0.00

Displaying 2 Items

#	Payment	Adjustment	Name	Posted To	Posting Level	Health Plan	Policy Number
1	$0.00					BC WASHINGTON PREMERA PPO	
2	$0.00					BC WASHINGTON PREMERA PPO	

Status: Working
Policy Number:
Payment Method:
Adjustment:
Deductible: $0.00

Sequence: 1
Converted Payment: $0.00
Payment Description: 20220514110008770ECZP0
Adjustment Alias:
Remark: CO-97 - Pmt included in allow for other svc/proc - $121.35

Payment: $0.00
Check Date:
Adjustment Group/Reason:
Entered By: System

Payer: BLUE CROSS WASHINGTON PREMERA
Received From: PREMERA BLUE CROSS
Adjustment Type:
Guarantor:

Payment Alias: 4600
Payment Identifier:
Copay: $0.00
Claim DOS: 04/06/2022

Health Plan: BC WASHINGTON PREMERA PPO
Payment Type: Insurance payment - DOD Insurance Payment
Coinsurance: $0.00

CPA Denials Management Features

Workflow | Remittances

Personnel: Cerner Test, Patient Accounting - Biller/Claims Rep Cerner

Status	Count	Amount	Percent of Total Count
At Risk Claim	8	$1,169.00	1%
Credit Balance	8	($420.25)	1%
Discharged, Not Ready to Bill	241	$52,668.57	
Edit Failure	158	$19,738.51	
EOB Variance	19	$1,936.01	3%
Generated Claim	1	$325.32	<1%
In House	100	$22,410.56	17%
Past Due	1	$221.00	<1%
Pending Edit Claim	20	$922.89	3%
Pending Reimbursement Claim	3	$450.00	<1%
Ready to Bill	10	$53.00	1%
Tech Denial - Additional Info Needed	2	$10,010.00	<1%
Tech Denial - Benefits	2	$10,010.00	<1%
Tech Denial - Billing Submission Errors	2	$10,010.00	<1%
Tech Denial - Medical Necessity	3	$15,020.00	<1%
Tech Denial - Provider/Phys Follow-up	2	$10,010.00	<1%
Tech Denial - Registration/Eligibility	1	$5,010.00	<1%
Tech Denial - Reimbursement	2	$10,010.00	<1%
Totals:	**583**	**$169,554.61**	**100%**

- Recovery tool used to track and reconcile accounts
- Allows users to access information, in one location, which is used in denials management
- Focus on high dollar accounts

Common Reasons for Claim Denials

- Non-participating provider
- Medicare EOB required
- Incorrect dates of service
- Termination of coverage
- Failure to obtain pre-authorization
- Non-covered benefit
- Untimely filing
- Out-of-network provider utilized
- Procedure or service not medically necessary
- Additional Information Needed
- Coding Errors
- Incorrect Demographic information

Types of Denials

Actionable Denials

- Amount of Coverage
- Registration Inaccuracies
- MTF Did Not Comply with UR Procedures
- Other

Un-actionable Denials

- Patient Not Covered, Care Provided Not Covered, or Policy Expired
- TRICARE and/or Income Supplemental Plans
- Medicare Supplemental Plans
- HMO/PPO
- Patient Copays and Deductibles

Types of Denials, cont.

Clinical Denials

- Medical Necessity
- Delay in Discharge/Procedure
- Alternate Setting
- LOS exceeds Authorization

Administrative Denials

- Failure to pre-certify
- Lack of clinical information
- Lack of Benefits
- Exclusion Denials

Understanding Denial Reason Codes

- Challenges in understanding denials:
  - Variance in denial reason codes by payer
  - Denial reason does not necessarily identify the real issue
  - Inconsistently applied codes even with same payer
  - Missing denial codes
  - Denial codes that don’t fit the reason the claim was denied
- Always best to call the payer for explanation. Some payers offer live online assistance through chat windows on their website.

Denials - Best Practices

- Early Intervention
  - Respond to denials immediately
  - Establish a timeline for working denials
  - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
  - Monitor and act upon unresolved denials
  - Follow-up on all levels of appeals process
  - Measure denials and appeal results
  - Trend issues by payer and reason
- Impact of Best Practices
  - Improved cash flow due to an increase in clean claims and a reduction in denials

How to Establish a Best Practice

- Streamline billing responsibilities
  - Dedicate team specifically to manage denials
  - Standardize appeal templates by payer
- Show impact on revenue
  - Total amount denied by type
  - Denied amount as a percentage of revenue
  - Total write-off amount by transaction code
  - Write-off amount as a percentage of revenue
  - How much has been collected
- Establish goals
  - What is an acceptable percentage to write-off due to denials (point of reference - industry goal is 3%)
- Communicate results to leadership

Payer Communication

- Effective and continual communication with payers is essential
  - Develop standards for what information is required
  - Read the EOB carefully
  - Understand payer specific guidelines
  - Call the payer if a denial reason needs clarification
  - Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences
  - Develop process for receiving policy updates
  - Establish procedures for documenting communications

Payer Communication, cont.

- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long do I have to resubmit the claim?
  - Does the payer need any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a claim when it is resent to indicate that it is a corrected claim?
  - Where does the information need to be sent?
  - Is there a reference number for this phone call?
  - If payer representative is not helpful, ask to speak with a supervisor

Communication Between Billers and MTF Staff

- Front Desk Staff
  - Registration
  - Other Health Insurance (OHI) collection
- Clinical Staff
  - Complete and accurate medical record documentation
  - Timely closing of encounters to avoid coding backlogs
- Coding
  - Accurate coding is necessary for receiving payment
  - Build relationships with coders so clean claims can be produced

Information Request

Balances

Balance: Institutional, Primary, 11/21/2018 - 11/21/2018

Activity Summary:
Type: Institutional
Balance: $10.00
End Date: 11/21/2018
Late Charges Only: No
Authorizations:
Insurance: Aetna
Rolled Reason:
Patient Member Number: 3523423
Remaining Estimated Balance:

Workflow Info: Edit Failure
Status: Generated
Non-Covered Amount: $0.00
Holds: No
Subscriber: BEN ROBINSON
Financial Class: Commercial
Rolled By:
Balance Associations:
Policy Number:

Add Billing Hold
Apply Action Code
Apply Comment
Associate Balance For Billing
Bill as Institutional
Bill as Professional
Bill Late Charges
Complete
Create AP Refund
Generate Adjustment Interim Claim
Generate Claim
Generate Continuing Interim Claim
Generate Final Interim Claim
Generate Initial Interim Claim
Identify Work Item
Modify Patient Responsibility
Set As Generated
Set as Ready to Bill
Set As Waiting Previous Balance Completion
Transfer Balance

- CPA feature used to request information internally
  - E.g., Coding correction, medical records, registration, or balance review

Process For Handling Claim Denials

- Interpret the EOB to ensure that a valid denial reason has been received
- Determine if it needs to be written off or billed to the patient
- Determine if denial can be corrected and resubmitted or if the claim requires an appeal
- Develop a communication plan
- Engage appropriate departments
- Establish goals for follow-up
- Develop your case based on the payer’s guidelines
- Monitor corrected or appealed claims

Appealing Denials

- Denied claims should be pursued aggressively
  - Denied claims should be prioritized based on date and dollar amount
  - Aggressive does not mean calling every day
  - Scrutinize all denied claims for incorrect information
  - Disputed claims should be communicated to the payer in writing
  - Aggressively appealing denials has been shown to reduce denial rates

Follow-up on Appeals

- Insurance companies frequently do not pay what they approve
  - They have no incentive to ensure that everything is paid appropriately
  - Track payments for approvals or overturns
    - ✓ When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial
  - Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute
- What About Upheld Denials?
  - Request the payer send supporting documentation
  - For incorrect payments, request a copy of the fee schedule
    - ✓ A list of CPT codes and dollar amounts a payer will allow for a particular medical service

Tips for Tracking Denials

- Why track denials?
  - Defines where breakdowns are in the process to identify opportunities for performance improvement
  - Identifies unreasonable payer practices
  - Collaborative effort appeals are easier to handle in the future
  - Identifies areas where denial management efforts have been successful
  - Allows UBO to develop future goals and opportunities for preventing future denials

Tips for Tracking Denials, cont.

- Grouping claim denials
  - Payer and type
  - Reason
  - Develop denial categories
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Show impact on revenue
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
  - Communicate to leadership

Tips For Submitting Clean Claims

- If paper claims must be filed:
  - Use only original claim forms
  - Make sure claims are printed clearly
  - Avoid folding claims, if possible
  - Avoid using terms such as “re-filed claim” or “second request”
  - Avoid handwritten claims
  - Don’t use all UPPERCASE letters
  - Don’t use punctuation or decimals on claims
  - Don’t send unnecessary attachments
  - Don’t use staples, paperclips or post-it notes
  - Don’t mark up the claim with highlighters
  - Don’t use circles or additional markings
  - Don’t attach labels or stickers
  - Don’t add notes or instructional assistance
  - Make a copy

Summary

- Be sure to understand the denial codes on the EOB
- Focus on effective communication with payers
- Develop a strategic plan for managing individual claim denials
- Develop a method for tracking claim denials and appeals
- Make sure claims are “clean” before they are sent

Questions?